CO54-003-e
CSARR coding of rehabilitation-readaptation acts in three SSR Clinalliance clinics. Six-month experiment
P. Meyer a, T. Roditi b,⁎, M.K. Steneck a
a Clinalliance Pierrefitte-sur-Seine, soins de suite et réadaptation neurologique, 32, avenue Victor-Hugo, 93380 Pierrefitte-sur-Seine, France
b Groupe Clinalliance CRF Villiers-sur-Orge, France
⁎Corresponding author.
E-mail address: patrice2meyer@gmail.com
Keywords: CSARR nomenclature; Catalog of rehabilitation and readaptation acts; Notion of global act; CCAM (common classification of medical acts); IRA (indicator of activity value); PMSI (Program for medicalization of information systems); ICF; Common language
We present our statistics and our coding experience of CSARR (catalog of rehabilitation and readaptation acts) in neurorehabilitation, EVC-EPR, orthopaedics, geriatrics and cardiology, along with some protocol examples. A quantitative comparative between CDARR and CSARR reveals a similar increase of the IRA value (indicator of activity value) with a decrease of two-thirds of declared acts.
The CSARR nomenclature, which codes PMSI (Program for medicalization of information systems) rehabilitation acts and will be mandatory on July 1, 2013, borrows from the CCAM (common classification of medical acts) in regard to the change towards T2A SSR tariffs announced for 2016. The CSARR introduces the notion of global act and is characterized by an appliance-based classification, a medical wording accessible to professionals, a significant part dedicated to orthoses, more collective acts and a chapter dedicated to therapeutic education. Part of the wording describes the entire performing of an act, enumerating the main elementary tasks. Modulators characterize the patient and/or the localisation of the performance. Operators (prepositions, conjunctions, phrases, punctuation signs), conventional symbols (brackets, parentheses) and notes define reading and coding rules thoroughly. The concept of the wording construction refers to the pre-norm preEN 1828 of CEN and to functions described in International Classification of Functioning, Disability and Health (ICF) and it never refers to a particular healthcare professional.
Experiment feedback exposes the advantages of CSARR which describes better the course of rehabilitation acts. Prescription is more intuitive, which suits better integrated care pathways. A workgroup set up at the ATIH (technical agency for hospitalization information) will allow CSARR users’ observations to be responded to: classifying development, errors correction, integration to the regrouping in GME.
http://dx.doi.org/10.1016/j.rehab.2013.07.695

CO54-004-e
Prospective payment system in post-acute care: Impasse or opportunity for reform?
J.P. Devailly a,⁎, L. Josse b
a CHU Bichat-Claude-Bernard, Assistance Publique–Hôpitaux de Paris, 46, rue Henri-Huchard, service de médecine physique et de réadaptation, 75018 Paris, France
b Hôpital Rothschild, Assistance Publique–Hôpitaux de Paris, France
⁎Corresponding author.
E-mail address: jpdevailly@gmail.com
Keywords: Rehabilitation; Post-acute care; Prospective payment system; Case-mix; Financing
Objectives—The transition to a prospective payment system (PPS) in french hospital sector of post-acute care (SSR) has been postponed to 2016. Assuming that the current impasse is linked to the construction methodology for the medico-economic groups (GME), the objective of this study is to provide, through analysis of the work of countries involved in the construction of pricing activity in post-acute sector, a method of classifying patients suitable for SSR and in particular the fair valuation of PRM activities.
Methodology—We analyzed the available foreign works on the Internet concerning the organization and financing of post-acute care. We selected the models developed in the USA, Belgium, Switzerland and Australia. Comparisons with the French system focuses on the health model selected, the identification of rehabilitation in the process of segmentation of activities, capture tool, taking into account outpatient care, construction methodology of patients classification systems and unit payment.
Results—The classification GME built by French agency for information on hospitalization (ATIH) foreshadows a payment “per case”. It does not reflect the different processes of care, but the categories of the 2008 decrees. Foreign models have in common the reference to ICF model, a clear definition of the concept of rehabilitation, a classification whose the first level is the medical purpose of care, and whose classes of patients are based on their needs, identified by a combination of disease and comorbidities, robust indicators of functional limitations, personal and environmental factors. The Australian system includes outpatient. The payment unit seeks a balance between payment per diem weighted by activity, payment per case, and fixed block grant.
Discussion—The first level of a coherent medico-economic classification in post-acute sector must match the major goals of medical management. Their description as care programs help to formalize clinical objectives for target populations by linking treatment modalities, predictable resources and evidence. A reform of PMSI-SSR must precede the fair valuation of rehabilitation activities. Their specification is complementary to better integrated care pathways.
Further reading
http://dx.doi.org/10.1016/j.rehab.2013.07.696

CO54-005-e
Respective contribution of chronic conditions to disability in France: Results from the national disability-health survey
C. Palazzo a,⁎, J.F. Ravaud b, M. Dalichamp c, L. Trinquart c, P. Ravaud a, S. Poiraudeau c
a Service de rééducation et réadaptation de l’appareil locomoteur et des pathologies du rachis, hôpital Cochin AP–HP, université Paris Descartes, PRES, 27, rue du Faubourg-Saint-Jacques, 75014 Paris, France
b Institut fédératif de recherche sur le handicap, Inserm, Paris, France
c AP–HP, centre d’épidémiologie clinique, hôpital Hôtel-Dieu U738, Inserm
⁎Corresponding author.
E-mail address: jpdevailly@gmail.com
Keywords: Rehabilitation; Post-acute care; Prospective payment system; Case-mix; Financing
Objectives—The transition to a prospective payment system (PPS) in french hospital sector of post-acute care (SSR) has been postponed to 2016. Assuming that the current impasse is linked to the construction methodology for the medico-economic groups (GME), the objective of this study is to provide, through analysis of the work of countries involved in the construction of pricing activity in post-acute sector, a method of classifying patients suitable for SSR and in particular the fair valuation of PRM activities.
Methodology—We analyzed the available foreign works on the Internet concerning the organization and financing of post-acute care. We selected the models developed in the USA, Belgium, Switzerland and Australia. Comparisons with the French system focuses on the health model selected, the identification of rehabilitation in the process of segmentation of activities, capture tool, taking into account outpatient care, construction methodology of patients classification systems and unit payment.
Results—The classification GME built by French agency for information on hospitalization (ATIH) foreshadows a payment “per case”. It does not reflect the different processes of care, but the categories of the 2008 decrees. Foreign models have in common the reference to ICF model, a clear definition of the concept of rehabilitation, a classification whose the first level is the medical purpose of care, and whose classes of patients are based on their needs, identified by a combination of disease and comorbidities, robust indicators of functional limitations, personal and environmental factors. The Australian system includes outpatient. The payment unit seeks a balance between payment per diem weighted by activity, payment per case, and fixed block grant.
Discussion—The first level of a coherent medico-economic classification in post-acute sector must match the major goals of medical management. Their description as care programs help to formalize clinical objectives for target populations by linking treatment modalities, predictable resources and evidence. A reform of PMSI-SSR must precede the fair valuation of rehabilitation activities. Their specification is complementary to better integrated care pathways.
Further reading
http://dx.doi.org/10.1016/j.rehab.2013.07.696